MENTALLY ILL OFFENDER CRIME REDUCTION GRANT (MIOCRG) PROGRAM

Program Evaluation Survey

ALAMEDA COUNTY DESIGN II . *BASIC EVALUATION*

1. Key Research Contacts:

County: ALAMEDA	
Researcher: Daniel Chandler, Ph.D.	Phone: 707 677 0895
Address: 436 Old Wagon Road Trinidad, Ca 95570	Fax: 707 677 0895
	E-mail:dwchandl@humboldt1.com
On-Site Research Manager: Gary Spicer, MBA	Phone: 510 567 8100
Address: Behavioral Health Care Services 2000 Embarcadero Cove Suite 400 Oakland, CA 94606	Fax: 510 567 8130
	E-mail:
Principal Data Collector: Will be hired in October, 2001	Phone:
Address:	Fax:
	E-mail:

Program Name:

Grant recipients have found it useful to pick a name that helps them to create a Program identity. Two examples are the IMPACT (Immediate Mental Health Processing, Assessment, Coordination and Treatment) project and the Connections Program. Indicate the name you will use to refer to your program.

Response: Telecare Criminal Justice Mental Health Program. The evaluation is termed BASIC in contrast to the experimental design of the CHANGES evaluation.

Research Design:

a. Check (✓) the statement below that best describes your research design. If you find that you need to check more than one statement (e.g., true experimental and quasi-experimental), you are using more than one research design and you will need to complete a separate copy of the survey for each design. Also, check the statements that describe the comparisons you will make as part of your research design.

	Research Design (Check One)
	True experimental with random assignment to enhanced treatment and treatment-as-usual groups
	Quasi-experimental with matched contemporaneous enhanced treatment and treatment-as-usual groups
	Quasi-experimental with matched historical group
X	Quasi-experimental interrupted time series design
	Quasi-experimental regression-discontinuity design
	Quasi-experimental cohort design
	Other (Specify)

Comparisons (Check all that apply)	
	Post-Program, single comparison between enhanced treatment and treatment-as-usual groups
	Post-Program, repeated comparisons (e.g., 6 and 12 months after program separation) between and within enhanced treatment and treatment-as-usual groups
	Pre-Post assessment with single post-program comparison between enhanced treatment and treatment-as-usual groups
X	Pre-Post assessment with repeated post-program comparisons (e.g., 6 and 12 months after program separation) enhanced treatment group and the same group used as historical control.
	Pre-Post assessment with repeated pre and post program comparisons between and within enhanced treatment and treatment-as-usual groups
	Other (Specify):

We are using a quasi experimental design with the experimental group serving as its own control group. Outcomes will be identified for those in the experimental group during the study period (two years of services and six months as a minimum opportunity for recidivism) and during a comparable baseline period.

The historical study group is defined by the *first* discharge from Unit One during the study period. All subsequent jail episodes count as recidivism for the study group members.

b. If you are using a historical comparison group, describe how you will control for period and cohort effects.

Response:

Not Applicable. Pre-study jail spells allow the tx group to serve as its own control. It will be important to include in regression models age of participant (as both criminal justice activities and mental illness diminish with age) and other person-specific information. A major variable is service in the Alameda County Behavioral Health Care system. A confounding effect is system change. While the basic system remains very similar to its form in the control period we will be attentive to documenting changes in this treatment context which might account for changes in service penetration.

Target Population:

Please identify the population to which you plan to generalize the results of your research. Describe the criteria individuals must meet to participate in the enhanced treatment and treatment-as-usual groups (e.g., diagnosis, criminal history, residency, etc.). Also, please describe any standardized instruments or procedures that will be used to determine eligibility for program participation and the eligibility criteria associated with each instrument.

Response:

The target population is mentally ill offenders with concurrent substance abuse/dependence diagnoses. Although the evaluation criteria limit this general population to some extent, we believe the finding from the study will generalize to all dual diagnosis mentally ill offenders.

Enhanced Treatment Group:

1. Indicate the process by which research subjects will be selected into the pool **from which** participants in the enhanced treatment group will be chosen. For example, this process might include referrals by a judge or district attorney, or selection based on the administration of a mental health assessment instrument.

Response:

The pool from which participants are chosen is persons eligible for TCJMHP program who meet the additional research subject criteria described above.

I. Eligibility for the Housing Unit One Telecare In-custody Program requires meeting the criteria in A, B and C.

A. Mental disorder: DSM IV diagnosis determined at index incident of in-custody treatment.
All DSM IV diagnoses are eligible with the exception of substance use disorder (as primary Axis I diagnosis), developmental disorder, or acquired traumatic brain disorder. Participants must also have a secondary Axis I diagnosis of substance abuse or dependence (including alcohol). Antisocial personality disorder may not be the only other diagnosis besides the substance use disorder.

AND:

B. Serious functional impairments or psychiatric history such that without treatment, there is imminent danger of further decompensation (especially in terms of the ability to engage in independent living, positive social relationships, and vocational opportunities). In making this determination the Criminal Justice Mental Health clinicians will review the person's history of psychiatric hospitalization, use of SSI, GA and other income supports, history of homelessness and on-going family relationships.

AND

C. The inmate is not a parolee, on his way to prison, or a resident of another county.

II. Additional eligibility requirements for research subjects

A. Participants must have at least two documented *previous* in-custody events in Alameda County during the period January 1, 1998–December 31, 2000; OR participants must have spent at least 90 days in the CJMH unit during the same period of time (including the index incarceration).
B. Persons with open records at a mental health or substance abuse treatment programs who have received at least one service during the 90 days prior to the index arrest are excluded from the experimental group as we otherwise could not measure a major outcome variable: stable links to a treatment provider.
C. Participant consent and release of information
Because subjects are identified post-hoc, only administrative data is used, and because no data is going to be used that includes any identifiers (the Evaluator will not be provided any individual identifiers) and because these services are being offered to *all* Unit One inmates neither an informed consent, an information release or human subjects approval is required or appropriate.

2. Indicate exactly how the enhanced treatment group will be formed. For example, it may result from randomized selection from the pool described in 5a above. Or, if the group size is small, a matching process may be required to achieve equivalence between the enhanced treatment and treatment-as-usual groups. In the case of a quasi-experimental design, the group may be a naturally occurring group. Please describe the origins of this group in detail, including an identification and description of matching variables, if used. If a quasi-experiment is planned, please describe the origins and nature of naturally occurring enhanced treatment groups.

Response:

The experimental group will be made up of all those who meet the identification criteria and who are discharged from Unit One (the CJMH unit) during the study period—which will comprise the first two years of the grant period. This time period permits generation of a large sample of approximately 600 to 800[1] and maintains a "risk of recidivism" period of at least six months (since data collection ends at 2.5 years). The experimental group itself is determined by the first discharge during the study period, with all other jail episodes counted as recidivism.

Treatment-as-Usual (Comparison) Group:

[1] We estimate approximately 30 clients per month or 360 a year for two years; however, this is not unduplicated clients. So the total number actually depends on the effectiveness of the program in reducing recidivism.

- Indicate the process by which research subjects will be selected into the pool **from which** participants in the treatment-as-usual group will be chosen.

  Response:

  No separate treatment as usual group. Group's history serves as control.

- Indicate exactly how the treatment-as-usual group will be formed. For example, if a true experiment is planned, the treatment-as-usual group may result from randomized selection from the subject pool described in 5a above. Or, if the group size is small, a matching process may be required in an attempt to achieve treatment-control group equivalence. If a quasi-experimental design is planned, the group may be a naturally occurring group. Please describe the treatment-as-usual group in detail, including an identification and description of matching variables, if used. If a quasi-experiment is planned, please describe the origins and nature of naturally occurring comparison groups.

  Response:

  Not applicable.

Historical Comparison Group Designs (only):

If you are using a historical group design in which an historical group is compared to a contemporary group, please describe how you plan to achieve comparability between the two groups.

Response:

NA. Group serves as own control.

Sample Size:

This refers to the number of individuals who will constitute the enhanced treatment and treatment-as-usual samples. Of course, in any applied research program, subjects drop out for various reasons (e.g., moving out of the county, failure to complete the program). In addition, there may be offenders who participate in the program yet not be part of the research sample (e.g., they may not meet one or more of the criteria for participation in the research or they may enter into the program too late for you to conduct the follow-up research you may be including as part of the evaluation component). Using the table below, indicate the number of individuals that you anticipate will complete the enhanced treatment or treatment-as-usual interventions. This also will be the number of individuals that you will be including in your statistical hypothesis testing to evaluate the program outcomes. Provide a breakdown of the sample sizes for each of the three program years, as well as the total program. Under Unit of Analysis, check the box that best describes the unit of analysis you will be using in your design.

We estimate approximately 30 clients per month will meet identification criteria or up to 360 a year for 2.5 years; however, this is not unduplicated clients.[2] So the total number actually depends on the effectiveness of the program in reducing recidivism. However, it is not feasible (nor ethical) to limit the in-custody and after care service intervention to only those who meet the experimental membership criteria. Feasibility is important because the criteria involve post hoc identification through merging of data bases. Treatment staff will not know who qualifies and who does not. Also it would not be ethical to not provide the experimental services simply because an inmate did not have a history of jail recidivism. That is, in order to document efficacy in reducing recidivism the evaluation will focus on persons with a prior history of jail use; but the services themselves cannot be so limited.

Sample Sizes (Write the expected number in each group)

[2] During 1996 through 1998 (36 months) there were 3,864 *persons* identified with a need for mental health services. This averages out to 1,288 per year. Based on a review of 166 recently discharged inmates, approximately 30 percent will meet length of stay and prior incarceration standards. This would amount to 386 person per year, which we are treating as the high end of the range.

Program Year	Treatment Group	Comparison Group
First Year	320	NA
Second Year	180	NA
Third Year	70 (6 month period to allow recidivism tracking)	NA
Total	570	

Unit of Analysis (Check one)	
X	Individual Offender
	Geographic Area
	Other:

NOTE: We are using an "intent to treat" design. Regardless of whether clients remain in contact with their assigned service providers they will remain in the study. The numbers above include anticipated attrition due to death, moving out of the county, or being unlocatable on any Alameda County data base to which we have access.

Enhanced Treatment Group Interventions:

Describe the interventions that will be administered to the enhanced treatment group. Please indicate of what the interventions will consist, who will administer them, how they will be administered, and how their administration will be both measured and monitored.

Response:

Alameda County Behavioral Health Care—in conjunction with Telecare Corporation—will provide the experimental program.

Expanded in-custody treatment

The plan also includes an enhancement of treatment services to the seriously and persistently mentally ill in custody. A contract with Telecare Corporation, a long-time mental health provider in Alameda County, will significantly improve the availability of in-custody treatment.

Telecare MHS Staffing Pattern

Position	*FTE*
Psychiatrist	1.0
Psychologist/Administrator	1.0
L.C.S.W./M.F.C.C.	3.0

The range of services that will be available through Telecare MHS includes the following:

- Assessment
- Consultation
- Medication Assessment
- Medication Management
- 1:1 counseling
- Referral to services—substance abuse services, medical services
- Skill Development
- Crisis Intervention and Brief Therapies
- Discharge Needs Assessment
- Discharge Planning
- Discharge Resource Development
- Group Interventions including education sessions, when and if appropriate

Assessment is particularly important due to the complexities of diagnosing persons with co-occurring mental and substance use disorders.[3] The evaluation will include identification of strengths, problems, resources, needs, and goals as well as potential areas of harm once inmates are released. Telecare staff will work with inmates on a 1:1 basis to increase strengths, skills, and resources and reduce harm in order to achieve the desired goals.

After care linkage/Short-term Transition Team Services

A major component of the new treatment services will be the development of aftercare linkages for all mentally ill offenders returning to the community after two weeks or more of incarceration. A plan will be jointly developed by Telecare staff and the inmate that addresses each of the inmate's goals . The short-term transition team will be staffed by two paraprofessional mental health staff with administrative staff support and access to a van. Whenever possible, an agency will be identified in the community which will provide services upon release. Inmates transitioning from the jail will be given priority access to community-based services. The transition team will have access to housing vouchers (approximately five rooms per night) to support immediate return to the community. Case managers from the identified agency will be invited to attend aftercare case conferences prior to release. Inmates being released locally will be given prescriptions by the psychiatrist. Inmates will be instructed on how to use the county pharmacy system to get the prescription filled upon release and be transported there if need be. However, mental health services alone are not sufficient. Though an inmate upon release continues his medication he may return to a homeless (or near homeless) situation. The transition team will use available housing vouchers and will work with the County housing resources, shelters, Berkeley Oakland Support Services, Bay Area Community Services, and other mental health and dual diagnosis housing services. The transition team bridges the in-custody and after-custody processes to avoid relapse and recidivism.

Treatment-as-Usual Group Interventions:

Describe the interventions that will be administered to the treatment-as-usual group. Please indicate of what the interventions will consist, who will administer them, how they will be administered, and how their administration will be both measured and monitored.

Response:

"Treatment as usual" historically involved stabilization rather than treatment (while in-custody) and minimum aftercare arrangements. No transitional services were available although clients were eligible for (and some used) the service continuum provided by Alameda County Behavioral Health Care.

Treatments and Outcomes (Effects):

Please identify and describe the outcomes (treatment effects) you hypothesize in your research. Indicate in the table below your hypothesized treatment effects (i.e., your dependent variables), their operationalization, and their measurement. Also indicate the treatment effect's hypothesized cause (i.e., treatments/independent variables) and the hypothesized direction of the relationship between independent and dependent variables.

Hypothesis	**Measure**[4]	**Instrument or data source**	**Type of analysis**[5]

[3] Carey, K. B., & Correia, C. J. (1998). Severe mental illness and addictions: assessment considerations. *Addict Behav, 23*(6), 735-748.

[4] We will be collecting, as required by the Board of Corrections, a variety of additional similar criminal justice, mental health and social functioning quantitative variables, and we will use them as appropriate. We are committing to collecting the information in the Data Dictionary promulgated by the Board of Corrections to the extent it is available. For example, the Performance Outcome System data is only collected on persons who meet medical necessity and are served long-term in the system. We do not propose to change any existing data systems or introduce new data systems for this evaluation.

[5] In all these analyses we will control for baseline characteristics made relevant by differential study attrition, if necessary.

The POST group will have a higher rate than the same group in the PRE period of "engagement" in treatment in the first 3 months after release	At least three visits with mental health/substance abuse clinician and an on-going open case at 3 months	INSYST (Behavioral Health Care MIS and billing system)	Survival analyiss with "failure" defined statistically as an on-going case at 3 months. [Likelihood Ratio Chi-2 in Cox model]
Experimental subjects will have more utilization of community-based mental health services in the POST period.	Average number of ambulatory MH service units per month: day treatment, case management, medications management	INSYST	Depends on distribution of the data: OLS regression or more likely zero inflated poisson regression (due to many zeroes) [Likelihood Ratio Chi-2 for model; z score for dummy on pre-post]
Experimental subjects will have fewer and less intensive contacts with the criminal justice system in the POST period[6]	▪ Arrests ▪ Jail days	Criminal justice data system: "Criminal Oriented Records Production Unified System" or CORPUS	Multiple failure survival analysis for recidivist incidents. [Likelihood Ratio Chi-2 in Cox model] Panel regression model for "count" data for days and arrests over time. [Wald Chi-2 for model; z score for significance of pre-post dummy]
Es will have less "negative" utilization of the MH/SA system in the POST period	▪ Psychiatric hospitalizations and inpatient days ▪ Detoxification episodes	Behavioral health MIS (INSYT)	Panel regression model for "count" data for days and arrests over time. [Wald Chi-2 for model; z score for significance of pre-post dummy]

Statistical Analyses:

Based on the table in #11 above, formulate your hypotheses and determine the statistical test(s) you will use to test each hypothesis. Enter these into the following table.

This has been added to the table in #11 above. Please refer the right hand column.

Cost/Benefit Analysis:

Please indicate whether you will be conducting a Program cost/benefit analysis of the program (optional).

Cost/Benefit Analysis			
	Yes	X	No

If you will conduct a cost/benefit analysis, describe what it will focus on and how it will be performed.

Response:

No Cost-Benefit analysis is proposed for the BASIC evaluation

[6] A recent study of legal system involvement of dual diagnosis clients in an integrated program found reduced arrests in the ACT clients but not reduced contacts that did not result in arrests. Clark, R. E., Ricketts, S. K., & McHugo, G. J. (1999). Legal system involvement and costs for persons in treatment for severe mental illness and substance use disorders. *Psychiatric Services, 50*(5), 641-647.

Process Evaluation:

How will the process evaluation be performed? That is, how will you determine that the program has been implemented as planned and expressed in your proposal? Please include a description of how will you will record and document deviations of implementation from the original proposal. Also, please identify who will conduct this evaluation and who will document the results of the evaluation.

Response:

A site visit by the independent evaluator will be conducted of the in-custody/transition program (and the CHANGES program) during the study group assignment period. Two other site visits will be scheduled at 9 month intervals. [Approximately 3 months, 12 months, and 21 months into the program.] The evaluator will be supplemented on site visits by a mental health consultant and an AOD/dual diagnosis consultant. Documentation of results is provided by the contractor as part of a series of scheduled reports.

During implementation the evaluator will consult frequently with custody staff, program staff and on-site data and evaluation staff. Documentation of essentials of the program (staffing, program elements) will be drawn from Contractor contract documents. The Contractor will also have a contract monitor from Alameda County Behavioral Health Care to assure accurate implementation.

Program Completion:

What criteria will be used to determine when research participants have received the full measure of their treatment? For instance, will the program run for a specified amount of time irrespective of the participants' improvement or lack thereof? If so, how long? Alternatively, will completion be determined when participants have achieved a particular outcome? If so, what will that outcome be and how will it be measured (e.g., decreased risk as measured by a "level of functioning" instrument)?

Response:

There are no completion criteria for the study; participants remain in the study during the entire study period. The experimental services terminate automatically after the initial linkage is made with housing, income, medication and treatment services (within 60 days).

Participant Losses:

For what reasons might participants be terminated from the program and be deemed to have failed to complete the program? Will you continue to track the outcome measures (i.e., dependent variables) of those who leave, drop out, fail, or are terminated from the program? For how long will you track these outcome measures?

Response:

Participants will not be terminated, though we anticipate a range of degrees of participation and utilization of available services (services are voluntary). Participants will, of course, continue to be tracked, after transitional services are over and all outcome measures will be derived from administrative data bases.